

Documentation Training



Presented by: Monica Gould, BA
January 25, 2012

Why is it important to document?

*Rule: If you don't document it,
then it didn't happen...*

- Measure of protection
 - Substantiate compliance with auditors
 - Records may be viewed by judges, attorneys, clients, etc. and help CM testify
- Measure of outcomes
- Reminder to you
- Coverage purposes
- Accurate history of crisis patterns
- Patterns of in/effective interventions
- Enhances quality of service
 - Especially with heavy case loads or in crisis situations

What does the NASW Code of Ethics Say?

- **3.04 Client Records**

- Social workers should take reasonable steps to ensure that documentation in records is accurate and reflects the services provided.
- Social workers should include sufficient and timely documentation in records to facilitate the delivery of services and to ensure continuity of services provided to clients in the future.
- Social workers' documentation should protect clients' privacy to the extent that is possible and appropriate and should include only information that is directly relevant to the delivery of services.
- Social workers should store records following the termination of services to ensure reasonable future access. Records should be maintained for the number of years required by state statutes or relevant contracts.

General Professional Guidelines

- Consider case management record to be a legal and/or medical document
- Documentation [and timeline] follows the agency/organization/state or other governing body protocols and these are followed in the charting.
- Documentation reflects any significant client, family or secondary service provider contact
- Do not leave blanks; write N/A (or not applicable)
- Mark any error with a single line and initials – never use correction fluid or tape
- Always explain to client documentation process and share with client when possible/appropriate (consider cultural concerns and history in response to "secrecy" of documentation)

Progress Notes

- Must prove “delivery of service” with: accurate, timely, objective, specific, concise, descriptive, consistent, substantive, & pertinent information.
- Outline reason for contact (client called requesting..., CM conducted scheduled home visit...)
- Write in third person and refer to all individuals by title
- Write in present tense and identify source for material that is controversial/potentially untrue/client perception.
 - i.e. “The client describes her parents as severe alcoholics rather than the client’s parents were alcoholics.”
- Describe client mood, affect, symptoms using client words first, then professional impression
- Always end notes with plan (CM will send referral, client will meet with housing CM...)
- When you record your “to-do” list, be sure to document outcomes and follow through

Progress Notes

- **Who** - The name, qualifications and/or title of the qualified staff providing the service or intervention.
- **What** –What was done, the specific interventions/skills training services provided.
- **Where** –The physical site where were the services provided (office, client's home, etc.).
- **When** –Date, length of service (in 15 min. units or time) and time of day.
- **Why** –Why were the services done. The intended goal, objective and outcome related to the interventions/skills training services.
- **How** –How the skills training was done (concrete, measurable & descriptive) along with the consumer's response and progress.

Documentation Format Styles

All Medicaid-styled case notes must include:

- client name, record number, and/or ID number; full date of service
- name of the service that was provided
- purpose of contact (tied to service plan)
- description of the interventions/treatment/support
- total amount of time spent performing the service
- effectiveness of the interventions
- proper signature of person who provided the service
 - for professionals, signature must include credentials, degree, or licensure
 - for paraprofessionals, signature must include the person's title/position

Documentation Format Styles Con't

Subjective, Objective, Assessment, Plan (S.O.A.P.):

- Subjective- document the client's own observations.
- Objective- what does provider perceive?
- Assessment- write about client progress
- Plan- document changes, additions, and revisions to care plan

Documentation Format Styles Con't

- **P-I-R:**

- **Problem(s)-Intervention(s)-Response(s)**

- **G-I-O:**

- **Goal(s), Intervention(s), Objective(s)**

- **G-I-R-P:**

- **Goal(s), Intervention(s), Response(s), Plan**

What to avoid?

- Never use casual abbreviations (use medical abbreviations)
- Do not take shortcuts at the cost of clarity (re-read out loud)
- Do not use generalizations or over-interpretations
- Grammatical errors...Spell check before finishing case note
- Avoid negative, biased, and prejudicial language. Write in a style that is factual, objective/unbiased, specific, and to the point without jargon.
- Omit details of the client's intimate life unless it's relevant to care plan.
- Avoid using medical diagnoses that have not been verified by a medical provider.
 - *client is depressed, rather say client states that he is having feelings of sadness or depressed mood). OR describe symptoms (client describes seeing hallucinations or is feeling sad on a daily basis)*

What to include?

- Highlight the client's strengths, supports and coping mechanisms
- Do not just report facts as you have been told. Instead, specify where the information came from (client reports/states, client is diagnosed with)
- Remember to report negative as well as positive observations/information/findings
- Each page should have client's name or identification

Additional Record Keeping Notes

- Consent forms and Release of Information (ROI) forms needed
- Request any important documents from outside agency for your records once the release is signed.
- Consent forms can be used for both verbal and written contact.
- Normalize the consent form process by introducing it during the intake and orientation process.
- Consent forms are time-limited.
- If a client is unwilling to sign a consent form, document the attempts to ensure that a request was made.

Tips and Suggestions

- Stay organized
- Carry notepad
- Maintain encounter log
- Account for “case noting” time
- Save time to document
- Secure time to document
- Utilize staff resources to improve